- I. Transmitted is a revision to Department of Veterans Affairs, Veterans Health Administration manual M-5, "Geriatrics and Extended Care," Part II, "Nursing Home Care", Chapter 3, "Community Nursing Home (CNH)."
- 2. Principal changes are:
- a. **Paragraph 3.01:** Discusses the reasons the Department of Veterans Affairs (VA) operates the CNH Program.
 - b. **Paragraph 3.02:** Describes the goals for patients placed in the CNH Program.
- c. **Paragraph 3.03**: Defines the responsibilities of the local CNH Oversight Committee, CNH evaluation team, and the CNH Coordinator..
 - d. Paragraph 3.04: Outlines the process for establishing a contract with a CNH.
- e. **Paragraph 3.05**: Defines VA standards of care particularly life safety and nursing service standards.
- f. **Paragraph 3.06**: Refines the VA evaluation process and places less emphasis on the formal annual evaluation.
 - g. **Paragraph 3.07**: Describes the patient placement process.
 - h. Paragraph 3.08: Defines the new standards for quality assessment and improvement.
 - i. Paragraph 3.09: Describes the application process.
- j. **Paragraph 3.10:** Describes the purpose of and standards for providing staff follow-up services, and sets new policy for follow-up of rehabilitation patients.
 - k. Paragraph 3.11: Defines all conditions related to placement period extensions beyond 6 months.
 - I. Paragraph 3.12: Defines reimbursement for basic care and ancillaries.
 - m. Paragraph 3.13: Sets cost ceilings for special CNH services which can be approved locally.
 - n. Paragraph 3.14: Outlines payment options for non-routine ancillary services.
 - o. Paragraph 3.15: Reviews the types of case-mix methods available and promotes their utilization.
 - p. Paragraph 3.16: Discusses CNH rate standards for non-Medicaid approved nursing homes.
- q. **Paragraph 3.17**: Outlines the four reasons for a rate exception and describes the process for obtaining one.
- r. **Paragraph 3.18:** Defines the process and timing of the annual rate certification by VA facility Directors.

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- s. Paragraph 3.19: Lists related policy guidance.
- t. **Appendix 3A:** Outlines quality of care and quality of life indicators in fifteen areas of nursing home services.
 - u. Appendix 3B: Provides instructions for completion of RCS 10-0168.
 - v. **Appendix 3C:** Defines information needed for CNH rate exception.
- 3. Filing instrctions

Remove pages	Insert pages			
3-1 through 3-9 Appendix A-1 through A-7	3-i through 3-ii 3-1 through 3-11			
Appendix B-1 through B-7	3A-1 through 3A-7			
-	3B-1 through 3B-2			
	3C-1 through 3C-3			

4. RESCISSIONS: M-5, Part II, Chapter 3, dated July 19, 1988; and VHA Directive 10-93-036.

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RESCISSIONS

The following material is rescinded:

1. Manuals

M-5, Part II, Chapter 3, dated July 19, 1988.

2. Circulars/Directives

10-93-036

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CHAPTER 3. COMMUNITY NURSING HOME (CNH)

3.01 POLICY

It is Veterans Health Administration (VHA) policy that nursing home care may be provided in licensed nursing facilities at Department of Veterans Affairs (VA) expense under the conditions and subject to the limitations prescribed in this chapter.

- a. The VA Community Nursing Home (CNH) Program is designed to assist veterans and their families in making the transition from an episode of hospital care, nursing home care, or domiciliary care to the community.
- b. The CNH Program serves the host VA facility as a primary vehicle in discharge planning for patients needing institutional long-term care. Local policies must ensure that veterans are placed in the CNH Program in an expeditious manner, thereby reducing hospital days.

3.02 SCOPE

The primary goal of the CNH Program is to maintain or restore the veteran to the highest level of health and well-being attainable. It is essential that arrangements for care respond to the veteran's needs at any given point in time and that a flexible long-term plan be initiated prior to placement. For many, placement will represent an interim period of care pending completion of arrangements to return to their own homes, community residential care facilities, or homes of relatives or friends. Others may need to remain in the nursing home indefinitely. Prior to a patient being placed in a CNH, plans should at least be in the developmental stage for obtaining necessary financial assistance for continuing care following termination of the contract.

3.03 RESPONSIBILITIES

- a. **CNH Oversight Committee.** Medical center Directors are responsible for establishing a CNH Oversight Committee. This committee consists of high level management, clinical and administrative staff, including Acquisition and Material Management (A&MM) staff, with involvement in the CNH Program.
- (1) The committee will meet as often as necessary, based on the volume of patient placements (the size of the CNH Program) and the number of CNHs under contract. The committee reports to the top management of the medical center.
- (2) The CNH oversight committee recommends local policy and monitors all program management and operations, including the following areas:
 - (a) Budget policy, in light of emerging, VA-supported, community-based long-term care programs.
 - (b) Patient placement policy.
 - (c) CNH Quality Assessment and Improvement Plan, and resulting data.
 - (d) Annual evaluation of CNHs and patient follow-up.

NOTE: An existing medical center committee, which already reports to the Chief of Staff through the Clinical Executive Board on all these issues, may perform this function, without creating a new committee.

b. **CNH Evaluation Team**. Medical center Directors are responsible for designating members of a CNH evaluation team and ensuring that transportation is available for evaluation of CNHs and patient follow-up.

- (1) At a minimum, the evaluation team consists of a professional nurse, social worker, physician, dietitian, pharmacist, fire safety officer, contracting officer, environmental management specialist, and a representative from Medical Administration Service (MAS). Staff from other services will be added to the team, as indicated. **NOTE**: The medical center Director will designate one team member, normally the social worker, as the coordinator.
 - (2) The function of the team is to:
- (a) Review all annual and any interim inspection findings of other agencies and follow-up on those findings.
 - (b) Review appropriate, available findings of the ombudsman or local complaint office.
- (c) Utilize results of quality assessment and improvement activities to improve care and correct problems.
 - (d) Utilize information gained in monthly follow-up visits to improve care and correct problems.
 - (e) When considered necessary, conduct as a full team or as a partial team, evaluations of CNHs.
 - (f) Recommend approval, disapproval, or termination of contracts.
 - (g) Provide guidance in the management of the CNH Program.
 - c. This review process will be fully documented by each team member.
 - d. The CNH coordinator will:
- (1) Acquire all appropriate quality of care inspection reports from regulatory agencies on a timely basis for CNH team review prior to evaluation.
- (2) Schedule review of new homes and annual re-evaluations on a timely basis in accordance with paragraphs 3.04 and 3.06.
- (3) Coordinate team action regarding approval, disapproval or termination of contracts, and inform the Contracting Officer of any issues which may affect contracting activities.
 - (4) Ensure appropriate, timely follow-up of veterans placed in CNH.
- (5) Develop working relationships with State and local regulatory and quality assurance agencies, ombudsman and/or complaints offices and ensure regular exchange of information with these offices.
- (6) Coordinate, as needed, surveys of the nursing home market, to ensure that the supply of nursing homes under contract is adequate to meet the needs of patients.
- (7) Provide necessary information to the CNH Oversight Committee, including information from quality assessment and improvement activities.
 - e. The Contracting Officer is responsible for negotiating and consummating contracts with CNHs.
- f. Follow-up of the veteran will normally be the responsibility of the placing facility and will be conducted primarily by Social Work and Nursing Services. Other services are expected to provide

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consultation to the CNH in the follow-up process as needed. For example, patients with an identified nutritional problem will receive follow-up visits as determined necessary by the dietitian.

g. A written referral will be made to another VA medical center or clinic when the distance to the nursing home or other circumstances make follow-up by the authorizing facility impractical. The referral will include patient specific information, including the name of the CNH and proposed admission and discharge dates.

3.04 PROCEDURE FOR INITIATING A CONTRACT

- a. When a nursing facility requests to participate in the CNH Program, the Contracting Officer, mails a Standard Form (SF) 129, Solicitation Mailing List Application; VA Form 10-1170, Contract Award for Furnishing Nursing Home Services to Beneficiaries of the Veterans Administration, and a descriptive cover letter to the applying nursing home.
- b. After return receipt of the application, an SF 98 and SF 98a, Notice of Intention to Make a Service Contract and Response to Notice, will be sent to the Department of Labor.
- c. The Contracting Officer notifies the team coordinator of the nursing facility's intent. An evaluation is planned according to procedures outlined in paragraph 3.06.
- d. Contracts with CNHs are meant to be shared among VA facilities, as needed for patient placement. The formal contract <u>can only be</u> established between a CNH and <u>one</u> VA medical center.

NOTE: VA has the right and responsibility to assess nursing homes, in order to be an informed purchaser of care. However, it should be clear that in assessing CNH, VA does not, in any way, regulate these homes, nor does it provide them with any credentials following completion of a successful assessment.

3.05 STANDARDS FOR NURSING FACILITIES

- a. The CNH must be licensed as a nursing facility by the state in which it is located and it must comply with applicable State and local government regulations.
- b. VA standards for CNHs are the same as those used for the certification of nursing facilities for the Medicare or Medicaid Programs with two exceptions.
 - (1) The CNH must meet the requirements of the latest edition of the Life Safety Code (NFPA 101).
 - (2) The CNH must meet the full Medicaid nursing service standard without waiver or exception.

3.06 EVALUATION OF NURSING FACILITIES

- a. CNHs will be evaluated prior to consummation of a contract with VA. A current accreditation as a long-term care facility by the Joint Commission on Accreditation Healthcare Organization (JCAHO) may be considered evidence of compliance with VA standards. If the medical center Director chooses to accept this method of evaluation, an onsite visit to the nursing home must be made only by the social worker and nurse, according to instructions outlined in subparagraph 3.06c. If the home is not JCAHO accredited or if the medical center Director chooses not to accept this method of evaluation, the home must be evaluated by one of the methods outlined as follows.
- b. When the CNH has been certified under Title XVIII (Medicare) or Title XIX (Medicaid), the CNH Coordinator, prior to evaluation, will obtain all the necessary State survey reports and other information outlined in subparagraphs 3.03b and 3.03d, including a copy of the most recent Form SSA 2567, Statement of Deficiencies and Plan of Correction. This document will note any deviation from standards,

the CNH's plan for correction, and any waivers. **NOTE**: *The CNH evaluation team members will review Form SSA 2567 prior to the CNH evaluation*.

- c. When the review of Form SSA 2567 and the other information outlined in subparagraph 3.03b is satisfactory, no full team inspection is required or expected. A visit will be made to the home by the team social worker and nurse only. The purpose of this visit will be to describe and evaluate:
- (1) The quality and level of care provided including staffing, quality control programs, training, services, rehabilitation, care management, nutrition and corresponding documentation.
- (2) The quality of life in the facility including environment, safety, flexibility to accommodate lifestyle, participation of residents and families, system to assess satisfaction, and response to concerns and complaints.
- (3) Facility programs designed to meet the needs of veterans including medical, social and spiritual, and activities promoting self-worth and a sense of well-being.
 - (4) Special characteristics and unique programs of facilities.

NOTE: Appendix 3A, Community Nursing Home Care (CNHC) Program: Quality of Care and/or Quality of Life Indicators, may be used in this evaluation.

- d. The description and evaluation is to be documented and will be used to determine how this facility might best be used to serve the needs of the target veteran population.
- e. If a review of Form SSA 2567 or other information from the CNH team's review raises questions as to the suitability of the home for the use of VA beneficiaries, appropriate members of the VA team, including the Contracting Officer, or the entire team, if indicated, will visit the home to resolve the questions, applying the cited Title 42 Code of Federal Regulations (CFR) standards and documenting the findings.
- f. Based on this evaluation processes, recommendations will be made by the CNH team coordinator to the Contracting Officer for disposition of the application. If problem areas are noted, the CNH must be advised of the deficiencies in writing by the Contracting Officer and given a reasonable amount of time to take corrective action. A contract may be issued while corrective action is being pursued only if the health and safety of the veteran is not compromised.
- g. The evaluation process will be completed and documented every 12 months and no more than 90 days prior to expiration of the contract. If a contract is canceled and renegotiated during the year for the purpose of establishing a new per diem rate, it is not necessary to conduct another evaluation as long as the evaluation has been conducted within the required 12 month time limit.
- h. When serious deficiencies affect the health or safety of veterans, or in cases of continued uncorrected deficiencies, VA medical centers should consider the following actions:
 - (1) Suspend placement of veterans to the CNH.
 - (2) Remove and/or transfer veterans under contract from the CNH.
 - (3) Not renew the contract.
 - (4) Terminate the contract.

NOTE: VA medical centers may conduct onsite evaluations on a routine sampling basis as determined by the team coordinator. It is the clear intention of the VA to eliminate unnecessary and redundant Federal inspections of CNHs through the processes outlined in this chapter. However, it is emphasized that the

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VA medical center retains the right and carries the responsibility to conduct an onsite VA evaluation by a full or a partial team at any time it is considered necessary to ensure that quality care is provided to veterans in a safe environment.

- i. Nursing facilities not certified under Title XVIII (Medicare) or Title XIX (Medicaid) will be evaluated on site by the following CNH team members: social worker, nurse, dietitian, fire safety officer, and contracting officer, using the standards outlined in 42 CFR. The team physician, clinical pharmacist, environmental management specialist, and any other discipline will be included in the inspection as indicated by the team's review of the information outlined in subparagraph 3.03b. The social worker and nurse members of the team will, in addition to applying standards of 42 CFR, describe and evaluate the facility according to the principles outlined in subparagraph 3.06c.
- j. VA medical centers will, on their own initiative, make available to Health Care Financing Administration (HCFA), State survey agencies and ombudsman offices, information about facilities which are found to have significant deficiencies which may threaten the health or safety of residents.

3.07 SELECTION AND MOVEMENT OF PATIENTS

- a. Prior to placement in a CNH, consideration will be given to post-contract planning. If there clearly is no viable post-contract plan and the veteran will most likely be returned to the VA medical center, the veteran may not be placed in a CNH.
- b. Selection of patients for placement in CNHs will be approved by the Chief of Staff, or if designated by the Assistant Chief of Staff (ACOS) or appropriate bed service chief, once eligibility has been determined by MAS.
- c. Patients will be given the opportunity to choose a nursing home from facilities approved by and available to VA. **NOTE:** *Listings of local nursing homes will be maintained by each VA facility.*
- d. Early planning will be initiated to ensure that needed dental care, prosthetic appliances or assistive devices are furnished prior to discharge from the VA facility.
- e. VA Form 10-1204, Referral for CNH Care, will be prepared by staff responsible for discharge planning. The responsibility for providing the necessary information rests with the patient's physician, nurse, social worker, dietitian, and other staff involved in the patient's care.
- f. The original VA Form 10-1204, a copy of VA Form 10-1000, Discharge Summary, and other pertinent documents will be forwarded to the nursing home so that they are available when the patient arrives. A copy will be filed in the patient's consolidated health record (CHR) folder at the medical facility. An additional copy will be reproduced and forwarded to the facility which is to conduct the follow-up, if other than the authorizing facility.
- g. A CNH retains the right to refuse to accept any patient when it is anticipated that the cost of the care and services required would exceed the scope of the contractor's ability to meet the medical needs of the veteran.

3.08 QUALITY ASSURANCE IN THE CNH PROGRAM

- a. The VA medical center will integrate the CNH Program in its yearly Quality Assessment and Improvement Program.
- b. A CNH quality assurance plan, including clinical indicators, will be developed through the combined efforts of the CNH Oversight Committee, the CNH evaluation team and the VA medical center's quality assurance staff, as outlined in subparagraph 3.03a.

- c. CNH clinical indicators may include, but are not limited to, patient deaths at the CNH and patients or family complaints about the CNH. For patients readmitted to the medical center from CNHs, clinical indicators may encompass, but are not limited to the following areas:
 - (1) CNH acquired pressure ulcers;
 - (2) Falls with injury;
 - (3) Medication errors with adverse effects; and
 - (4) Other issues as determined by the medical center.
- d. Patients readmitted to the VA medical center from CNHs will be evaluated for incidents in accordance with M-2, Part I, Chapter 35.
- e. Results of quality assessment and improvement activities will be used by the oversight committee and the evaluation team to improve care and make decisions about renewing contracts.

3.09 HOSPITAL DISCHARGE PLANNING IN CERTAIN CASES

When a patient or the family objects to the CNH placement, the procedures outlined in M-5, Part III, Chapter 2, paragraph 2.17, will be used.

3.10 PLANNING AND FOLLOW-UP

- a. VA has an obligation to ensure the quality of care in CNHs and to demonstrate that veterans served in this program are no less a part of the VA continuum of extended care than are veterans cared for in VA nursing homes. VA provides follow-up services to the veteran in the CNH in order to monitor, information, and guide their care in the home.
- b. Prior to placement of the veteran in the CNH, a plan should be developed for follow-up services needed from the VA medical center. This plan should be developed by the staff from Nursing and Social Work Services, in consultation with the referring bed service. The plan should delineate on an individual patient basis:
 - (1) The particular needs of and the services provided to the patient which should be followed,
 - (2) Which members of the team will provide the follow-up, and
 - (3) The frequency of the follow-up visits of the designated team members.
- c. Every VA patient in a CNH must be visited by a VA staff member at least every 30 days. At a minimum, a nurse must visit VA patients at least every 60 days. Other professional disciplines should make follow-up visits when indicated by the patient's discharge plan, a change in their condition, or other factors.

NOTE: It is important to emphasize the individual basis of this plan. When visits become routine, there is a danger that the focus will be lost and that quality will suffer.

- d. In addition to the specific follow-up plan for the patient, VA follow-up staff will convey to the nursing home staff their observations about the quality of professional care provided and provide the CNH staff with guidance. Specific professional discipline responsibilities include:
 - (1) The social worker will make follow-up visits as often as necessary to:
 - (a) Provide consultation and liaison related to care management and provide patient advocacy.

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(b) Assist the patient and family with the social and emotional aspects of the transition to long-term care.

- (c) Address unresolved patient and/or family concerns and/or complaints with CNH staff.
- (d) Assist the patient and family in planning for continued care in the nursing home or transition to another level of care in the community, if indicated, and coordinate the application for maximum VA benefits post contract.
- (e) Provide consultation to CNH staff related to discharge planning and coordinate referrals to VA medical center services.
 - (f) Make observations about the CNH to inform the evaluation of the facility.
 - (2) A nurse will make follow-up visits to ensure that adequate and safe care is being provided and to:
 - (a) Provide consultation and liaison related to care management and provide patient advocacy.
 - (b) Monitor quality of care.
 - (c) Review plan of care for individual patients, as indicated.
 - (d) Determine if referral to dietitian is indicated.
 - (e) Make observations about the CNH to inform the evaluation of the facility.
 - (3) A dietitian will make follow-up visits as determined necessary to:
- (a) Investigate identified nutritional problems following a review of State inspection reports and evaluate the care provided;
- (b) Contact the staff or contract dietitian within 1 month concerning noted dietary deficiencies of patients placed at the CNH; and
- (c) Provide education and consultation to CNH staff for the purpose of enhancing nutrition care services.
- e. Patients receiving rehabilitation therapies at VA expense require special follow-up services to ensure that the therapies are provided and continue to be clinically indicated.
- (1) A VA physician will order the therapy(s) or approve the CNH's plan for therapy for a specific period of time. Orders for therapy(s) will not exceed 1 month, but may be recertified.
- (2) A copy of the therapy notes will be sent to the VA medical center each month by the CNH for review by the appropriate team members, with consultation from other services as needed.
- (3) VA staff providing follow-up visits to the CNH will observe therapy sessions when possible and review the therapy notes.
- f. If plans for continued nursing care at non-VA expense for a veteran whose hospitalization or need for nursing home care was primarily for treatment of nonservice-connected disabilities are feasible, but the veteran or family decline to cooperate, the VA authorization will be terminated. Written notification of the pending termination will be made to the veteran or family, the CNH and any other interested parties. Termination will be effective 30 days following written notification or at the expiration of the current authorization, whichever comes first.

g. Patients remaining in the CNH at VA expense for an extended period of time (more than 1 year) will be given a comprehensive physical examination no less often than once a year to determine the need for continued nursing home care. Such examinations will be done, to the extent practicable, on a staff basis at the VA medical facility nearest the CNH. If this is not feasible, the examination will be done at the CNH on a fee basis, or by a VA physician, physician's assistant or nurse practitioner, with referral to a physician, as indicated. The report of examination will be reviewed by the CNH team to determine the need for continued care. A copy of the report of examination will be furnished to the CNH for inclusion in the patient's record.

3.11 EXTENSIONS BEYOND 6 MONTHS

- a. Extensions beyond 6 months for veterans whose hospital, nursing home, or domiciliary care was primarily for treatment of nonservice-connected disabilities will be held to a minimum and must meet one of the following conditions when the need for nursing home care continues to exist:
- (1) Arrangements for payment of such care through a public assistance program (such as Medicaid) for which the veteran has applied, have been delayed due to unforeseen eligibility problems which can reasonably be expected to be resolved within the extension period, or
 - (2) The veteran has made specific arrangements for private payment for such care, and
- (a) Such arrangements cannot be put into effect as planned because of unforeseen, unavoidable difficulties, such as a temporary obstacle to liquidation of property, and
 - (b) Such difficulties can reasonably be expected to be resolved within the extension period; or
- (c) The veteran is terminally ill and life expectancy has been medically determined to be less than 6 months.
- b. All cases meeting the preceding requirements will be fully developed and documented, including recommendations of the physician, nurse and social worker. Cases will be forwarded to the medical center Director for a decision on the requested extension at least 5 days prior to expiration of the current authorization.
- c. Extensions must be for a specific period of time, not to exceed 45 days, for cases under subparagraph a.(1) and a.(2)(a) and (b).

3.12 BASIC REIMBURSEMENT RATE STRUCTURE

- a. VA uses Medicaid rates for room, board, and routine nursing care.
- b. VA adds a factor of not more than 15 percent for routine ancillary services. These services are:
- (1) Drugs,
- (2) Nursing supplies,
- (3) Oxygen (occasional use),
- (4) X-ray,
- (5) Laboratory,
- (6) Physician visits, and
- (7) Rental equipment.

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- c. Every effort will be made to secure contracts which include the items in subparagraph 3.12b.
- d. Contracts negotiated with exemptions for ancillary services listed in subparagraph 3.12b, will reflect a reduced per diem rate by the estimated daily cost of the exempted items.

3.13 REHABILITATION AND OTHER HIGH COST SERVICES

- a. Rehabilitation therapies and special equipment, e.g., clinitron beds, are not considered routine ancillary services.
- b. The daily cost of rehabilitation therapy will not exceed 60 percent of the per diem rate, without approval of the Assistant Chief Medical Director (ACMD) for Geriatrics and Extended Care.
- c. The daily cost of Special Care and Clinically Complex patients, as defined in VA's Resource Utilization Group (RUGII) classification, will not exceed 26 percent of the per diem rate, without approval of the ACMD for Geriatrics and Extended Care.
- d. The daily cost of patients with Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS), and needing specialized care, will not exceed 80 percent of the per diem rate, without approval of the ACMD for Geriatrics and Extended Care.
- e. Drug costs which comprise more than 7.5 percent of the per diem rate are generally not considered routine ancillary services.

3.14 PROVISION OF NON-ROUTINE SERVICES

- a. Items, classified as non-routine services, but needed for the care of a veteran placed in the CNH Program, will be provided in one of three ways.
- (1) A special contract rate will be devised that includes the cost of non-routine ancillary services. For example, the VA medical center can develop a standard skilled care rate and a standard skilled rate that includes therapies. The latter rate would apply only for those patients approved by VA for therapy for a specified time period.
- (2) Veterans in CNHs at VA expense may be entitled to outpatient services, supplies and equipment (including prosthetic and similar appliances) in accordance with 38 CFR 17.60, 17.115c and 17.120 through 17.123b. The services, supplies and equipment may only be provided when not normally considered part of the CNH package and not included in the contract. When appropriate, these additional services must be authorized in advance according to M-1, Part I, Chapter 12, paragraph 12.34.
- (3) Items, especially drugs, can be provided directly by the VA medical center. Appropriate cost adjustments should be made to the CNH account. **NOTE:** This approach is not recommended for therapies.
- b. Special follow-up procedures for patients receiving rehabilitation services are found in subparagraph 3.10e.

3.15 ADJUSTMENTS FOR CASE-MIX (LEVELS OF CARE)

- a. States have reacted differently to the HCFA dissolution of the skilled nursing facility and/or intermediate care facility (SNF/ICF) levels of care
- b. . States have considerable latitude in establishing Medicaid rate policy. Some states have adopted a single Medicaid rate for all patients regardless of care requirements. Others have maintained two levels of payment based on the old SNF/ICF system. Still others have developed a multiple level case-mix system.

- c. In determining which approach it should take to rate setting, the VA medical center should first consider the range of needs (and therefore the range of costs) of patients normally placed and the number of patients placed each year. If the range varies significantly and there is a sufficient volume of patients, the VA medical center may find it prudent to negotiate several levels of reimbursement. These levels can be based on the State's case-mix system, or a modification thereof.
- d. In states that use a single or unitary rate for all levels of care, the VA medical center is still free to negotiate multi-level rates, based on the RUGII classification, which defines levels of care. In either case, multiple rates can better approximate the actual cost of care for individual patients. When the VA medical center places patients who have similar level of care needs, or when the volume of placements is insignificant, a single rate may be appropriate.
- e. In all cases, VA medical centers should choose an approach to rate setting for different levels of care that is acceptable to the CNH team and the CNH provider.

3.16 OTHER RATE STANDARDS

- a. The rate methodology for CNHs which do not participate in the Medicaid Program will be approved by the Office of Geriatrics and Extended Care (114A), VA Central Office. Criteria for approval include:
 - (1) Actual cost of care at the non-Medicaid-participating CNH; and
 - (2) The relationship between that cost and Medicaid reimbursement for similar CNHs in the area.
- b. Rates for care of unusually complex, e.g., ventilator-dependent or other sub-acute categories, will continue to be approved by the ACMD for Geriatrics and Extended Care, VA Central Office.
- c. A supply of medications is often provided to the patient at the beginning of the placement period. This transitional supply of drugs should not exceed a 7-working day supply. **NOTE:** *The 7-working days may or may not include a weekend; this policy fulfills a General Accounting office recommendation*

3.17 EXCEPTIONS TO BASIC RATE STRUCTURE

- a. Exceptions to the policy outlined in paragraph 3.12 are provided in four cases. These are:
- (1) Lack of availability of quality nursing home care provided within the Medicaid-plus policies and other factors, e.g., geographic location of beds within the Primary Service Area (PSA) in relation to the veteran population.
 - (2) Special services, e.g., special programs for Alzheimer's patients.
- (3) Indicators of quality, including a CNH's demonstrated ability to care for difficult-to-place patients, the provision of activities programs geared to male patients and other quality factors found in appendix 3A.
 - (4) Ancillary costs exceed 15 percent for VA patients.
- b. VA medical centers must seek exceptions when a rate within the Medicaid-plus policy cannot be established and the CNH team determines that a contract with the CNH is in the best interests of the care of veterans.
- c. The information required for an exception will be developed by the CNH team and submitted by the VA medical center Director to the Regional Director, or designee. The request for an exception will contain information outlined in Appendix 3C.
 - d. All exceptions must be approved prospectively by the Regional Director, or designee.

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Chapter 3

3.18 ANNUAL CERTIFICATION PROCESS

a. On an annual basis, each VA facility Director will submit a statement to the appropriate VHA office certifying that each CNH contract meets the rate policy, or has been granted an exception. The number of contracts meeting the policy and the number of exceptions will be included in the certification statement.

- b. The certification statement is due on the 15th workday of March and should cover the period from March 1 in the previous year through the last day of February of the current year.
 - c. Appropriate VHA offices will review a sample of contracts at selected facilities.

3.19 OTHER RELATED TOPICS - CNH CARE

The policy on the following policy related issues is found in M-1, Part I, Chapter 12:

- a. Eligibility,
- b. Active military duty,
- c. Procedures in Alaska (AK) and Hawaii (HI). **NOTE:** There are no VA medical centers in either state.
 - d. Readmission to a medical center,
 - e. Additional care,
 - f. Billing and reporting procedures,
 - g. Deaths and notification of adjudication,
 - h. Due process,
 - I. Authorization,
 - j. Releases,
 - k. Outpatient care,
 - I. Institutional awards and non-bed care (NBC) status,
 - m. Admission of women veterans,
 - n. Other administrative procedures,
 - o. Reduction in pension benefits,
 - p. Change of address or cancellation of direct deposit, and
 - q. Billing discretionary veterans.

COMMUNITY NURSING HOME CARE (CNHC) PROGRAM QUALITY OF CARE AND/OR QUALITY OF LIFE INDICATORS

The following is a list of areas of observation of nursing home care, defined by Department of Veterans Affairs (VA) Community Nursing Home (CNH) staff over the past 10 years, which, when applied with professional judgment, can be indicators of the quality of care and the quality of life in nursing homes.

1. Physical Environment

- a. Attractiveness of building,
- b. Maintenance of building,
- c. Maintenance of grounds,
- d. Lighting of interior,
- e. Adequacy of privacy and personal living space,
- f. Privacy for resident and/or family counseling and/or visitation,
- g. Absence of offensive odors,
- h. Absence of excessive noise,
- i. Condition of furnishings,
- j. Suitability of furnishings,
- k. Accessibility of total facility to all residents,
- I. System for monitoring and/or protecting wanderers, and
- m. Temperature and/or climate control system.

2. Staff

- a. Staff Attitude and Behavior
- (1) Promptness of staff response to resident calls for assistance,
- (2) Staff courteousness to residents and appropriate interaction,
- (3) Staff knowledge of individual residents,
- (4) Staff respect for personal privacy of residents,
- (5) Staff response to care of terminally ill and staff preparation and care for terminally ill, and
- (6) Staff knowledge and use of community and other resources.
- b. Staff Training

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- (1) Orientation and training of new employees,
- (2) Inservice education matched to identified needs,
- (3) Staff training in Cardiopulmonary Resusitation (CPR),
- (4) Affiliation with student programs, and
- (5) Opportunities for continuing education.
- c. Quality Assurance
- (1) Representation by all departments at regular quality assurance meetings,
- (2) Staff input to development and/or revision of policy procedures, and
- (3) Federal and/or State deficiencies corrected timely and appropriately.

3. Compliance with Life Safety Code Regulations (NFPA 101).

4. Safety Practices and Procedures

- a. Resident care equipment availability, utilization, and maintenance;
- b. System for resident identification;
- c. Accessibility of call system in bedroom and/or bathroom;
- d. Safety of bathtubs and/or showers, and hallways;
- e. Storage of potentially hazardous solution (ingestibles); and
- f. Acceptable practice in cleaning premises.

5. Staffing Patterns and/or Bed Capacity

- a. Sufficiency of staff and/or resident ratio,
- b. Continuity of staff,
- c. Use of temporary staff, and
- d. Staff grooming and clothing.

6. Patient Care Services

- a. Personal Care and Hygiene
- (1) Evidence of appropriate personal hygiene;
- (2) Patients ability and availability of providing personal hygiene;
- (3) Privacy in toilet and bathing areas;
- (4) Types and number of toilet and/or bathing areas per patient;

- (5) Accessibility of toilets and/or baths;
- (6) Flexibility of routine to allow resident control in daily activities;
- (7) Assistive devices for use of toilet and bathing areas;
- (8) Appropriateness of resident clothing;
- (9) Frequency of access to beautician or barber;
- (10) Appropriate informed consent for care procedures;
- (11) Restraint reduction program;
- (12) Use of indwelling catheters;
- (13) Access to fluids;
- (14) Menus and types of meals being served;
- (15) Assistance with eating, if needed; and
- (16) Condition of skin.
- b. Rehabilitation and/or Specialty Programs
- (1) Weight monitoring system;
- (2) Decubitus ulcer care;
- (3) Bowel Training Program;
- (4) Bladder Training Program;
- (5) Staff skill in care of gastrostomy and/or tracheostomy, naso-gastric tube feeding, and/or Oxygen, and/or intravenous therapy.
 - (6) Staff skill in care of bedfast residents;
 - (7) Nursing rehabilitation programs for enhancement of independence;
 - (8) Appropriate use of mirrors, clocks, calendars, orientation cues;
 - (9) Availability of appropriate supplies and equipment; and
 - (10) Facility sponsored programs, such as: hospice, respite, adult day health care, etc.
 - c. Policy and Procedure Manuals
 - (1) Development by facility staff,
 - (2) Documentation of annual update,
 - (3) Accessibility to staff,
 - (4) Restraint policy and/or procedure (chemical and/or physical),

- (5) Indwelling catheter policy and procedure,
- (6) Medical emergencies, and
- (7) Functions of the CNH Medical Director.
- d. Infection Control Measures
- (1) Handwashing accessibility,
- (2) Linen-storage and management,
- (3) Utility room-use and storage, and
- (4) Isolation procedures and/or policies.

7. Medication Management

- a. Storage of medications,
- b. System for dispensing,
- c. Documentation of medication administration,
- d. Notation of reason given/results obtained,
- e. Review for side effects and drug interactions,
- f. Monitoring of all medications to avoid polypharmacy,
- g. Documentation of reason for as needed (PRN) medications and results,
- h. Medication orders checked by consultant pharmacist, and
- i. Appropriate monitoring of emergency medications.

8. Medical Care

- a. Frequency of physician visits to residents,
- b. Physician availability as needed with appropriate consultation and/or care planning response,
- c. Physician orders signed within 48 hours with follow-up system, and
- d. Do Not Resuscitate (DNR) policy and/or Supportive Care Guidelines.

9. Consultants

- a. Dietitian,
- b. Physical Therapist,
- c. Speech Therapist,
- d. Podiatrist,

- e. Occupational Therapist,
- f. Psychiatrist,
- g. Pharmacist,
- h. Dental, and
- i. Others, as needed.

10. Clinical Records

- a. Initial assessment by physician and/or nurse and/or social worker;
- b. Resident care plans reflect current needs, goals, and actions;
- c. Documentation reflects implementation of care plan;
- d. Care plans evaluated and revised appropriately;
- e. Appropriate rehabilitation and/or discharge plans; and
- f. Records and charts are well organized.

11. Policies and Practices Affecting Resident Satisfaction

- a. Facility's recognition of residents' religious and/or ethnic autonomy;
- b. Resident access to spiritual counseling and religious activities;
- c. Encouragement by facility of family and resident in care planning;
- d. Flexibility of resident bedtime and/or waking hours;
- e. Encouragement of family and resident to participate in decisions of daily life;
- f. Effectiveness of resident and/or family council to influence home policy;
- g. System for assessing resident satisfaction;
- h. Programs for orienting new residents and their families;
- i. Response system to resident and family complaints;
- j. Residents' freedom to personalize own room with adequate space, and access to funds and possessions;
 - k. Openness and flexibility of visiting hours;
 - I. Practices to accommodate lifestyle of residents;
 - m. Resident participation in selection of roommate;
 - n. System to accommodate resident sexuality issues and/or practices; and

o. Programs to enhance self worth and self esteem.

12. Activities

- a. Opportunities for productive activities,
- b. Availability of appropriate recreational and/or diversional and/or quality of life in activities and programs,
 - c. Facility system for assessing resident interests,
 - d. Balance between sedentary and physical activities,
 - e. Opportunities for activities in community,
 - f. Balance of activities for male and female residents.
 - g. Activity opportunities for bedfast residents,
 - h. Availability of current and appropriate reading material,
 - i. Opportunities for community activities in nursing home,
 - j. Use of sensory stimulation programs and/or orientation cues,
 - k. Availability of community transportation,
 - I. Availability of evening and/or weekend activities,
 - m. Facility's ability to recruit volunteers from varied sources, and
 - n. Utilization of volunteers in various programs.

13. Unique Features and/ or Programs

14. Interaction with VA Follow-up Staff Since Last Evaluation

- a. Openness to suggestion and/or constructive criticism,
- b. Responsiveness to criticism and/or complaints, and
- c. Timeliness of response.

15. Nutrition

- a. Establishment and periodic update of nutritional care plans,
- b. Maintenance record of feeding hydration of residents,
- c. Maintenance of height and weight records,
- d. Visitation by dietitian or food service supervisor or consultant with resident,
- e. Practices for responding to residents' food likes and dislikes,
- f. Provision for selective menus,

- g. Provision for food substitutes,
- h. Provision made to help resident and family understand diet,
- i. Provisions of in-between meal and bedtime snacks for residents,
- j. Timeliness of meal service,
- k. Flexibility of meal schedule,
- I. Appeal and appearance of food,
- m. Level of sanitation,
- n. Encouragement of congregate eating,
- o. Residents' satisfaction of foods served,
- p. Suitability of dining facilities,
- q. Provisions for special occasions as birthdays and holidays,
- r. Established monitoring of food intake and identification of patients with inadequate intake,
- s. Provision of adaptive feeding devices, and
- t. Provision of assistance for patients requiring help during meals.

INSTRUCTION FOR COMMUNITY NURSING HOME (CNH)REPORT, RCS 10-0168

1. CNH REPORT, RCS 10-0168 (OLD RCS 18-3)

Following are the instructions for the preparation of the CNH Report, RCS 10-0168. The CNH Report provides information to the Department of Veterans Affairs (VA) Central Office and the Department of Health and Human Services about nursing homes under contract to VA. It is the only source of data about individual CNHs and is used for preparing budget requests, program analyses as well as answering inquiries from Members of Congress and other interested people.

2. INSTRUCTIONS

- (a) Paragraph 3 provides instructions for preparing the report for electronic submission.
- (b) Each VA facility will report, on a quarterly basis, information regarding CNH facilities under contract. CNH facilities with no veteran patients during the period will also be reported.
- (c) VA medical centers will report only those nursing homes for which the medical center maintains the contract. For example, if a medical center in New York State places a veteran in a CNH in Pennsylvania under the jurisdiction of another VA medical center, that nursing home should not be listed as a contract for the New York State facility.
- (d) Submissions will be sent electronically to the Austin Automation Center (AAC) and are due at the AAC by the 10th workday of the month following the end of the guarter.
- (e) Each medical center has a designated coordinator for this report. The coordinator will ensure the accuracy and timeliness of the report. The coordinator will ensure that any errors are corrected within established timetables, the last day in the month following the end of the quarter.
 - (f) Each VA facility will receive a report of the CNH facilities under contract with systemwide totals.

3. CODING INSTRUCTIONS FOR RCS 10-0168, CNH REPORT

- (a) Item 1. Blocks 1-3. Three Digit Station Number. Enter in blocks 1-3 the three digit number for the VA medical center reporting the patient. (Refer to current Consolidated Address Bulletin).
- (b) Item 2. Blocks 4-26. Name of CNH. In block numbers enter the complete name of CNH. If the name is composed of two or more words, skip a block between each word. Abbreviations will be necessary for many of the names (see following list); however, proper names should not be abbreviated. Where abbreviations are used, it is not necessary to skip blocks between each word. The following standardized abbreviations will be used:
 - N Nursina
 - H Home or Hospital
 - C- Convalescent or Center
 - R Rest, Rehabilitation or Restorium
 - S Sanitarium
 - G Geriatric
 - I Incorporated
 - SC Senior Citizen
 - HA Home for the Aged.
- (c) Item 3. Blocks 27-41. City Where CNH is Located. Enter the complete name of the city where the CNH is located. If the name is composed of two or more words, skip a block between each word.

Abbreviations will be necessary for many of the names, however, proper names should not be abbreviated. Where abbreviations are used, it is <u>not</u> necessary to skip blocks between each word.

- (d) <u>Item 4. Blocks 42-43. State Code Where CNH is Located</u>. Enter the two digit code for the State in which the CNH is located. The codes to be used will be found in M-1, Part I, Appendix B.
- (e) <u>Item 5. Blocks 44-46. County Code Where CNH is Located</u>. Enter the three digit code for the county in which the CNH home is located. The codes to be used will be found in M-1, Part I, Appendix B.
- (f) <u>Item 6. Blocks 47-49. Beds</u>. Enter the total number of beds in the CNH which are licensed nursing home beds.
- (g) Item 7. Block 50. Facility Inspected or Accredited. Enter the letter "I" in the block if CNH has been evaluated by VA personnel. Enter the letter "A" in the block if the CNH is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). If the CNH is accredited by JCAHO, and inspected by VA personnel, enter the letter "B."
- (h) <u>Item 8. Blocks 51-56. Per Diem Rate</u>. In blocks 51-53, enter the highest per diem rate charged by the home for care per the contract. In blocks 54-56, enter the lowest per diem rate charged by the CNH per the contract. If there is only one contract rate at the CNH, enter the rate in blocks 51-53 and enter zeros in blocks 54-56. All per diem rate should be rounded off to the nearest dollar.
- (i) <u>Item 9. Block 57. Medicare and/or Medicaid Certification</u>. This item refers to certification for Medicare under Title XVIII and for Medicaid under Tile XIX of the Social Security Act. The codes 1, 2, 3, and 4 will be used as follows for block 57:
 - 1 Not certified for either Medicare or Medicaid
 - 2 Certified for Medicare only
 - 3 Certified for Medicaid only
 - 4 Certified for both Medicare and Medicaid
- (j) <u>Item 10. Blocks 58-60. Number of Veterans.</u> Enter in blocks 58-60, the number of veterans in the nursing facility at VA expense on the last day of the reporting period. Since the purpose of this entry is to indicate the actual usage of a given contract facility for the care of veterans at VA expense, the contracting VA medical center should include all veterans in the CNH whose care is purchased by VA, regardless of the source of VA payment, that is, which medical center is paying for it. This data should be available from Social Work Service which provides follow-up to veterans in the home. Veterans in the CNH at their own or other non-VA expense are not to be included.
- (k) <u>Item 11. Blocks 61-64. Date of Last Assessment</u>. Enter the month (blocks 61-62) and the year (blocks 63-64) that the CNH was last evaluated by either a partial or full VA team.

c. Medicare (__percent).

FORMAT FOR REQUEST FOR APPROVAL OF COMMUNITY NURSING HOME (CNH) PER DIEM RATE

Department of Veterans Affairs (VA) medical centers must provide concrete evidence that acceptable the local has ption

alternatives to provide the needed nursing home care within the rate policy are not available in the community. Generalizations such as "we have not been able to find this quality of care in other local nursing homes" are not acceptable. In this example, there must be written evidence that the market has been surveyed and the level of quality care unavailable. A VA medical center request for a rate exception will include information that follows in the same order and with the same numbers:
1. VA medical center name.
2. VA medical center number.
3. Name and position of VA medical center staff member contact.
4. Telephone number (FTS and Commercial) and FAX number (FTS and Commercial) of VA medical center staff member contact.
5. Name of CNH.
6. City and State of CNH.
7. Indication whether this is a new contract or a renewal of contract, and date of contract, if renewal.
8. Number of beds in CNH.
9. Occupancy rate of CNH.
10. Existing VA Per Diem Rate.
11. Per Diem rate VA medical center is requesting be approved.
12. Medicaid rate for the CNH for the level of care under review and the date the rate was effective.
13. Medicaid-plus-15 percent rate.
14. Medicare rate, where applicable, for the CNH and the date the rate was effective.
15. Private pay rate (average daily charge for private pay patients for comparable services).
16. Total expenses for the CNH as reported in the CNH's most recent Medicaid Cost Report:
17. Total days of care in the CNH as reported in the CNH's most recent Medicaid Cost Report.
18. Period covered by the Medicaid Cost Report.
19. Distribution (in percents) of bed occupants by primary payment source:
a. Medicaid (percent).
b. Private pay (percent).

d.	Other	(_	percent).								
	`	,	Distribution st 6 months:	(in percents)	of bed	occupants	by primary	payment	source	at tim	ne of
a.	Medicaid	(_	_percent).								
b.	Private pa	y (_	percent).								
C.	Medicare	(_	_percent).								
d.	Other	(percent).								

21. Quantitative Information

- a. Reason(s) rate exceeding Medicaid-plus-percentage is required. Circle all that apply:
- 1 Beds not available at quality CNHs under Medicaid-plus-percentage policy.
- 2 Special Care Services.
- 3 Consistent High Quality.
- 4 Ancillary Costs Exceed 15 Percent.
- b. Specific justification for requested per diem rate, including documentation of cost-related factors:
- (1) If the reason for exception request involves bed availability in quality CNHs, the justification should include, as appropriate:
- (a) Comparison of CNHs "total cost" to Medicaid Program's adjusted "total cost", stating what costs are not covered by Medicaid.
 - (b) Statement of State Medicaid rate increases for inflation in past 3 years.
 - (c) Other relevant information regarding State Medicaid rate setting, e.g., casemix.
 - (d) Information on bed availability from VA's August 1993 survey of CNHs.
 - (e) Nursing home bed occupancy in city or county or area where CNH is located.
- (f) Other techniques used to determine bed availability, including review of CNHs already under contract; CNHs previously under contract; and periodic local bed surveys.

NOTE: In the case of the preceding items (a) through (f), only information that directly relates to the exception request should be provided.

- (2) If the reason for exception request involves special care services, the justification should include:
- (a) Description of special services, staffing and equipment used.
- (b) CNH cost of providing services by standard sub-accounts in paragraphs 3.12 through 3.14 and other special accounts.

NOTE: When providing cost information, VA patient costs are preferred. When this information is not available, average costs for other patients is acceptable. When the service is new, costs estimates may be necessary.

- (3) If the reason for exception request involves consistent high quality care, the justification should include a statement describing those elements outlined in subparagraph 3.17a(3).
- (4) If the reason for the exception request involves ancillary costs in excess of 15 percent, the justification should include CNH cost information by standard sub-accounts in paragraphs 3.12 through 3.14, and other special accounts for VA patients. The note following item (2) applies in this case.
- c. Derivation of Requested Rate. Provide CNH and other cost information, with any VA medical center adjustments, by standard sub-accounts in paragraphs 3.12 through 3.16, that indicate how the requested rate was determined.
- 22. Narrative Statement. Briefly explain why this rate is needed.